ASSESSMENT OF THE CLINICAL SOCIAL WORKER DEMONSTRATION

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EXECUTIVE SUMMARY

The Direct Reimbursement of Clinical Social Workers Demonstration Project was developed in response to a congressional mandate to test whether recognizing clinical social workers (CSWs) as independent practitioners, rather than having them bill through a supervising physician as currently required under Medicare regulations, would improve access to needed mental health services for Medicare beneficiaries and whether it would be a cost-effective method of delivering care.

The demonstration project, sponsored by the Health Care Financing Administration, ran from January 1, 1984, through December 31, 1985. During this period, licensed CSWs practicing in seven Southern California counties were eligible to receive direct reimbursement from Part B of Medicare for outpatient mental health services. In general, any Part B mental health service for which Medicare approves reimbursement of physicians and that CSWs may legally perform was covered.

The demonstration assessment addressed the implementation and operation of the program and its outcomes; i.e., administrative feasibility of direct reimbursement to CSWs, and implications of direct reimbursement in terms of the use of services and Medicare Part B program costs.

The implementation and operation assessment indicated that inclusion of CSWs in Medicare is administratively feasible. After initial implementation problems were resolved, administering the program was straightforward for the Medicare claims processor, requiring minimal additional effort.

The outcome assessment indicated that utilization of CSW services was low.

- Less than 0.1 percent of the aged population, and less than 0.2 percent of the disabled, used CSW services. Less than 3 percent of all Medicare eligibles use any mental health services.

- Only 18 percent of the certified CSWs participated by submitting at least one approved service.

- CSW services represented 3 percent of all approved mental health services.

The assessment also indicated that CSWs served a different patient population, and provided different types of services, than did mental health service providers who were not CSWs. CSWs primarily served beneficiaries who were aged and had nonpsychotic mental health conditions, whereas other mental health services providers (psychiatrists and medical groups/clinics) generally served beneficiaries who were disabled and had psychotic conditions. CSWs relied more on psychosocial interventions than did psychiatrists and other providers, who used medications extensively. CSWs were far more likely than other mental health service providers to deliver group and family therapy services and to provide services in a patient's home.

During the 2-year demonstration, the level of utilization of CSW services was low. If the demonstration's conditions of little or no CSW utilization continued after permanent expansion of CSW coverage, then direct reimbursement would likely have minimal additional impact upon Medicare costs. If, however, conditions changed after permanent expansion of CSW coverage so that CSW utilization increased, then direct reimbursement of CSWs could result in significant costs for Medicare.

Some evidence from the demonstration also suggests that direct reimbursement of CSWs would not achieve savings because substitution of lower-priced CSW services for higher-priced non-CSW services does not occur, nor do the greater costs of mental health services for CSW users offset demand for nonmental health services. The available evidence indicates that CSW services are not direct substitutes for mental health services from psychiatrists and other providers because the CSWs treat a different population than other providers. Although the overall cost of mental health treatment received by those who received CSW services was comparable to those who did not see a CSW, when compared, it appeared that for most diagnoses those seeing a CSW may have had somewhat more costly overall mental health treatment patterns than those who did not.

There is also no evidence that the potentially greater costs of mental health services for CSW users were offset by reduced demand for nonmental health services, although major differences in the populations of mental health service users who received CSW services and those who did not make direct comparisons between the groups difficult. Disabled CSW users, in particular, had substantially greater use of nonmental health services than did other disabled mental health service users.

Based on the low utilization of CSWs observed in this demonstration, and the lack of evidence that coverage of CSWs reduced total health care costs, the Department has concluded that the current statute concerning coverage of CSWs should not be changed.

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INTRODUCTION

The Direct Reimbursement of Clinical Social Workers Demonstration Project was developed in response to a congressional mandate[1/] to test whether recognizing clinical social workers (CSWs) as independent practitioners, rather than having them bill through a supervising physician as currently required under Medicare regulations, would improve access to needed mental health services for Medicare beneficiaries and whether it would be a cost-effective method of delivering care.

The demonstration project, sponsored by the Health Care Financing Administration (HCFA), ran from January 1, 1984 through December 31, 1985. SRI International, under contract to HCFA, assisted with the design, implementation, and assessment of the demonstration. Transamerica Occidental Life Insurance Company, which is the Medicare Part B carrier in the site where the demonstration was conducted, administered claims processing.

The following discussion of the results of the demonstration project is divided into four parts: a description of the demonstration, a summary of findings from the assessment of the outcomes of the demonstration, a summary of findings from the assessment of the implementation and operation of the demonstration, and policy implications drawn from the demonstration experience.

1/ Omnibus Reconciliation Act of 1980, Public Law 96-499, Section 958(d).

DESCRIPTION OF THE DEMONSTRATION

Objectives

The Direct Reimbursement of Clinical Social Workers Demonstration Project was intended to test: (1) whether direct reimbursement of CSWs would improve Medicare beneficiaries' access to needed mental health services; and (2) whether it would be a cost-effective method of delivering care.

Currently, Medicare will pay for the services of CSWs only if they are "incident to" the services of a physician. A physician must employ and directly supervise the social worker providing the services, and the bill for the services must be submitted through the physician.

Interest in extending independent practitioner status to nonphysician mental health providers such as CSWs was prompted by concerns over possible underutilization of mental health services by Medicare beneficiaries and the rising costs of the Medicare program. Extending independent practitioner status to CSWs could improve access to care by increasing the supply of providers. Costs might be reduced if:

- CSW services substitute for physician services and CSWs charge less for the same services or provide a less intensive mix of services than physicians;
- Utilization of CSW mental health services decreases use of nonmental health services and this decrease more than offsets the cost of the CSW mental health services; and
- Other mental health providers lower their prices in response to increased competition from CSWs.

On the other hand, extending independent practitioner status to CSWs could increase the cost of Medicare if CSW services are not substituted for mental health and other medical services provided by physicians; or if CSWs provide a more

costly mix of services; or if CSWs provide unnecessary services and induce inappropriate demand.

Demonstration Design

Under the demonstration, practicing CSWs in seven Southern California counties received direct Medicare Part B reimbursement for outpatient mental health services for 2 years, January 1, 1984 to December 31, 1985. The seven counties that comprised the demonstration area were Imperial, Los Angeles, Orange, San Diego, San Luis Obispo, Santa Barbara, and Ventura. Transamerica Occidental Life Insurance Company, the Medicare Part B carrier for these counties, acted as the Medicare carrier for the demonstration. All CSWs licensed by the Board of Behavioral Science Examiners of the California Department of Consumer Affairs were eligible to participate in the program after being certified as licensed and assigned a Medicare provider number by Occidental.

Before the demonstration began in January 1984, there was a 15-month design phase during which policies and procedures were developed and administrative activities were undertaken.

o Selection of the Demonstration Site

The demonstration site selected for this project had to be in a State that recognized CSWs as professionals and that had established professional standards through CSW licensure or registration and a CSW vendorship law. Licensure or registration, by which a State regulates the practice of social work, would provide a standard for eligibility to participate. Passage of a vendorship law, which requires insurance plans within a State to reimburse CSWs, was expected to increase the number of CSWs in the State with independent practices and with experience billing third-party payers. The site had to have a relatively large population of both Medicare beneficiaries and CSWs. Willing participation of a Medicare carrier was also required to provide for processing of CSW claims.

By May 1986, CSWs were licensed or registered in 36 States and in Puerto Rico, the Virgin Islands, and the District of Columbia; 15 of these States had a CSW vendorship law. California was one of the first States in the country to enact a vendorship law for CSWs. It has a large Medicare beneficiary population (approximately 1.5 million) and CSW population (approximately 4,700). The Medicare carrier serving Southern California was willing to process CSW claims.

o Administrative Policies, Procedures, and Publicity Activities for the Demonstration

Administrative policies included defining provider eligibility criteria (including whether salaried CSWs would be allowed to participate) and allowable types and places of service. Procedures included developing prevailing charges and claims adjudication processes, training claims examiners, modifying the claims procesing system, informing eligible CSWs about the demonstration, processing CSW applications for certification to participate, issuing supplier numbers to certified CSWs, and training CSWs in Medicare billing procedures for the demonstration.

In general, any Part B mental health services for which Medicare approves reimbursement to physicians and that CSWs may legally perform were covered. Reimbursement rates were developed by Occidental following the methodology normally used when any new provider or service is added to Medicare; i.e., by surveying providers in the area to identify customary prices for a service. The CSW survey was based on price lists from CSWs that were submitted as part of an application for certification to participate in the demonstration. The allowable CSW prevailing charge for a procedure, however, could not exceed the prevailing charge for psychiatrists in Los Angeles County.

CSW services were subject to the same annual limitations as other outpatient mental health services -- only the lesser of (1) $312.50 or

(2) 62.5 percent of the reasonable charges are considered as incurred expenses for purposes of payment under Part B. After the application of 20 percent coinsurance, there is a maximum annual reimbursement of $250.

Medicare supplemental insurance policies, which generally link coverage to Medicare-approved charges, covered CSW services during the demonstration. MediCal, the Medicaid program in California, did not pay for CSW services for Medicare beneficiaries with dual eligibility because their services were not covered under Medicaid.

During the design phase, CSWs and beneficiaries were informed about the demonstration. A letter was mailed to all licensed CSWs in the demonstration area, describing the demonstration and inviting them to submit an application for certification to participate. Activities to increase beneficiary and provider awareness and encourage participation included: enclosing a flyer announcing the demonstration, with Explanation of Medicare Benefits (E.O.M.B.) statements mailed to beneficiaries during the first week of January 1984; distributing a news release on the demonstration to all newspapers in the area; distributing a public service announcement on the demonstration to radio and television stations, including periodic announcements about the demonstration in social worker professional organizations' newsletters and the newsletter distributed by the carrier to providers in its service area; and appearances by representatives of the demonstration on radio and television interview programs. To assist beneficiaries in gaining access to CSW services, referral services were organized through the California chapter of the National Association of Social Workers and through the Society for Clinical Social Work.

ASSESSMENT OF OUTCOMES OF THE DEMONSTRATION

The outcome assessment is based on analyses of the use of and charges for Medicare Part B services during the demonstration, including CSW services, mental health services from psychiatrists and other providers, and nonmental health services. The assessment focuses on the types of beneficiaries served, the types of services provided, charges for mental health services, and charges for all Medicare Part B services. Each of these topics is discussed in the following sections.

Limitations of the Assessment

The main questions that the CSW demonstration project intended to answer were the impact of direct reimbursement of CSWs on the utilization and cost of Medicare services, both mental health and nonmental health. In addition, the demonstration examined access to care. The analysis of the demonstration was limited by the lack of information on Part A services, Part B services outside of Southern California, and beneficiaries' Medicare supplemental insurance coverage for mental health services. Complete information also was not available on access to care and on whether CSW services are substitutes for or add-ons to mental health services from other providers. In addition, as with any demonstration project, it was not possible to say whether a program of limited duration and only one site can predict the changes in supply and demand that would result if there were a permanent change in reimbursement under Medicare. Under the conditions of the demonstration, low utilization of CSW services occurred which would likely lead to minimal additional Medicare costs. If, however, behavior changed and utilization increased, then Medicare could incur significant additional costs.

Types of Beneficiaries Served

Only a small number of Medicare eligibles used CSW services, less than 0.1 percent of the aged population and less than 0.2 percent of the disabled. In comparison, less than 3 percent of Medicare eligibles use mental health services. Females, Caucasians, MediCal eligibles, and persons 75 years of age or over

(compared with those 65 to 74) were more likely to be CSW service users. Similar trends were found for the disabled. The percent urban and the CSW supply factor were not significant predictors of being a CSW user.

Most (84 percent) of the beneficiaries served by CSWs during the demonstration were 65 years of age or over; 45 percent were 75 years of age or over. Table 1 shows the age distribution, as well as other important characteristics, of CSW users and compares them with the characteristics of other users of mental health services who did not receive any CSW services.

Given the age distribution of CSW users, it is not surprising that 77 percent were originally entitled for Medicare because of age and only 23 percent were originally entitled because of disability. CSW users were mostly women (72 percent) and caucasian (94 percent). They lived mainly in the most heavily populated counties: Los Angeles (54 percent), San Diego (25 percent), and Orange County (17 percent).

Although MediCal did not participate in the demonstration and did not pay for the deductibles or copayments for CSW services, 29 percent of CSW users were eligible for MediCal, compared to 47 percent of other mental health users.

Most CSW users received mental health services from only CSWs during the demonstration, but 21 percent saw a psychiatrist or other provider for mental health services, in addition to a CSW, during this time period. Those CSW users who also saw another type of provider were more likely than other CSW users to be disabled.

Table 1

PERCENTAGE DISTRIBUTION OF MENTAL HEALTH SERVICE USERS BY SELECTED CHARACTERISTICS AND WHETHER THEY RECEIVED SERVICES FROM A CSW

Characteristic	CSW Users (N=1,424)	Other Mental Health Service Users (N=35,855)	All Mental Health Service Users (N=37,279)
Sex			
Male	28	43	42
Female	72	57	58
Entitlement			
Aged	77	51	52
Disabled	23	49	48
Age			
Under 65 Yrs.	16	42	41
65-74	37	35	35
75 Yrs. or Over	47	24	25
Race			
Caucasian	94	87	87
Black	4	9	8
Other	1	3	3
Unknown	1	1	1
County			
Imperial	1	1	1
Los Angeles	54	60	59
Orange	17	14	14
San Diego	25	19	19
San Luis Obispo	1	1	1
Santa Barbara	1	3	3
Ventura	1	4	4
MediCal Eligibles	29	47	46

Another difference between CSW users and other mental health service users is that 48 percent of those who did not receive CSW services had received mental health services in the 2 years before the demonstration, while only 13 percent of CSW users had done so. This difference is substantiated by the finding that baseline mental health service use was not a significant predictor (for CSW users) of the number of or allowed charges for CSW services during the demonstration, but it had a significant and positive impact on the use of and charges for mental health services received for all mental health service users during the demonstration.

The difference in the characteristics of beneficiaries suggests that the CSWs were serving a very different population than were the other mental health service providers. The latter were far more likely to see disabled beneficiaries, many of whom were probably disabled because of chronic mental illness. CSWs were serving an elderly population that had less chronic mental health problems.

The difference is further borne out by the diagnoses of patients seen by CSWs and other mental health service providers. CSWs saw mainly patients diagnosed with nonpsychotic disorders; 65 percent of the CSW users had diagnoses of neurosis or adjustment reaction. In contrast, mental health service users who did not receive services from a CSW were far more likely to be diagnosed with a psychotic disorder, with 52 percent diagnosed as having schizophrenia or affective psychoses.

Types of Services Provided

CSWs were more likely than psychiatrists to provide psychosocial group and family therapy services. While most CSW services were given in an office, as are those of psychiatrists, a substantial number were provided in the patient's home.

The service most frequently provided by CSWs was 50 minutes of individual therapy, accounting for 60 percent of all CSW services (Table 2). A sizable proportion of CSW services, 26 percent, were group therapy. Family therapy was the other service provided frequently, accounting for 8 percent of all CSW services.

Comparison of procedures billed by CSWs with those billed by psychiatrists and other providers of mental health services (most of whom were medical groups and clinics) suggests that CSWs relied more on psychosocial interventions in treatment of patients, while psychiatrists and other providers frequently billed for short individual therapy sessions (15 or 25 minutes), which were probably used to manage drug therapy. CSWs, thus, were more likely to provide 50 minutes of individual psychotherapy services than mental health service providers who were not CSWs.

Table 2

PERCENTAGE DISTRIBUTION OF APPROVED MENTAL HEALTH SERVICES BY PROCEDURE AND PROVIDER TYPE

Procedure	CSWs (N=9,626)	Psychiatrists (N=272,998)	Other Providers (N=21,815)	All Providers (N=304,439)
50 Minutes Indiv. Therapy	60	47	44	47
Group Therapy	26	5	8	6
Family Therapy	8	1	1	1
Other	5	47	47	46

The settings in which CSW services are delivered are a further indication of differences in the types of services they provide (Table 3). Like mental health services from psychiatrists and other providers, most CSW services (63 percent) were delivered in an office. However, unlike mental health services from providers who were not CSWs, a substantial number (27 percent) were provided in a patient's home. CSWs may do so either to make their services more available to patients who are unable to travel to an office or clinic, or to better evaluate the patient's social environment.

Table 3

PERCENTAGE DISTRIBUTION OF APPROVED MENTAL HEALTH SERVICES BY PLACE OF SERVICE AND PROVIDER TYPE

Place of Service	CSWs (N=9,626)	Psychiatrists (N=272,998)	Other Providers (N=21,815)	All Providers (N=304,439)
Office	63	74	56	72
Home	27	9	8	9
Long-Term Care	8	14	3	13
Outpatient Hospital	1	3	33	5

Charges for Mental Health Services

The total amount billed during the demonstration for approved CSW services was $540,556. The allowed charges for these services were $290,117, and $222,968 was reimbursed. The average amount billed per approved service was $51, the average amount allowed was $27, and the average amount reimbursed was $21. To place these figures in context, the prevailing charge for 50 minutes of individual therapy by a CSW was $55, the maximum allowable amount was $34, and the maximum amount that could be reimbursed was $28. CSWs billed an average of $1.21 per relative value unit (RVU is a standardized measure that can be used to compare the relative intensity of different services) were allowed $0.65, and were reimbursed $0.50.

Table 4 compares average charges for CSW services with those for psychiatrists and other providers. CSWs had a smaller average billed charge per service for mental health services ($51) than psychiatrists ($70) or other providers ($52). The average amount allowed per CSW service ($27) was less than the amount

allowed per psychiatrist service ($33), but more than that allowed per service from other providers ($24). Similarly, psychiatrists had the greatest amount reimbursed per service ($23), followed by CSWs ($21) and other providers ($18).

The same patterns hold for average charges per RVU for CSWs compared with psychiatrists and other providers. Looking at average charges per RVU takes into account differences between different types of providers in the intensity of the mix of services provided. CSWs had the smallest billed charge per RVU, $1.21, compared with $1.86 for psychiatrists and $1.39 for other providers. Their allowed and reimbursed charges per RVU were less than those of psychiatrists and very close to those of other providers. CSWs were allowed $0.65 per RVU, while psychiatrists were allowed $0.87 and other providers $0.64. The average amount reimbursed per RVU for CSW services was $0.50, compared with $0.62 for psychiatrists and $0.48 for other providers.

Table 4

AVERAGE CHARGES FOR APPROVED MENTAL HEALTH SERVICES BY PROVIDER TYPE

	CSWs	Psychiatrists	Other Providers	All Providers
Billed				
Per Svc.	$50.80	$69.57	$52.09	$67.73
Per RVU	$ 1.21	$ 1.86	$ 1.39	$ 1.81
Allowed				
Per Svc.	$27.37	$32.50	$24.18	$31.74
Per RVU	$ 0.65	$ 0.87	$ 0.64	$ 0.85
Reimbursed				
Per Svc.	$21.05	$23.04	$17.82	$22.60
Per RVU	$ 0.50	$ 0.62	$ 0.48	$ 0.60

Users of mental health services may receive treatment from more than one type of provider. When all mental health services received by a beneficiary, regardless of provider type, are taken into account, persons who used at least one CSW service and mental health service users who did not receive CSW services used comparable numbers of services, but CSW users had lower charges per person year of eligibility (Table 5).

Table 5

AVERAGE USE OF AND CHARGES FOR APPROVED MENTAL HEALTH SERVICES PER PERSON YEAR OF ELIGIBILITY BY PROVIDER TYPE

	CSWs	Psychiatrists	Other Providers	All Providers
CSW User				
Number of Svcs.	3.5	0.7	0.1	4.3
RVUs	148	28	3	179
Charges Billed	$179.17	$ 53.97	$ 4.50	$237.63
Allowed	$ 96.52	$ 24.92	$ 2.01	$123.45
Reimbursed	$ 74.25	$ 18.23	$ 1.48	$ 93.95
Other Mental Health Svc. User				
Number of Svcs.	0	4.1	0.3	4.4
RVUs	0	152	12	161
Charges				
Billed	$ 0.00	$283.94	$ 16.99	$300.93
Allowed	$ 0.00	$132.65	$ 7.88	$140.53
Reimbursed	$ 0.00	$ 94.02	$ 5.81	$ 99.83

The total number of mental health services received by CSW users averaged 4.3 per person year, with billed charges of $238, allowed charges of $123, and reimbursed charges of $94. Services from CSWs accounted for 81 percent of the total number of mental health services used by persons who had a CSW service and 78 percent of the allowed charges. Mental health service users who did not see a

CSW received slightly more mental health services per person year, 4.4, and had larger charges for these services: billed charges were $301, allowed charges $141, and reimbursed charges $100.

However, comparison of overall mental health treatment patterns between CSW users and mental health service users who did not see a CSW can be misleading because CSWs served patients with a very different mix of diagnoses than did psychiatrists and other providers, as shown in Table 6. When overall treatment patterns for CSW users are compared with those of other mental health service users with the same diagnoses, CSW users received more mental health services and, with the exception of patients diagnosed with adjustment reaction, had greater allowed charges.

CSW users with schizophrenia received 7.8 mental health services per person year with allowed charges of $244, while mental health service users who did not see a CSW received 5.7 mental health services with allowed charges of $170. For patients with affective psychoses, CSW users received 8.5 mental health services and had allowed charges of $223, compared with 4.3 services and $153 in allowed charges for other mental health service users.

CSW users with neuroses received a total of 4.6 mental health services and had $137 in allowed charges, in comparison with 2.7 services and $94 in allowed charges for other mental health service users. Although CSW users with adjustment reaction received more mental health services than mental health service users who did not receive CSW services, 4.0 compared with 3.0, allowed charges for mental health services received by CSW users were slightly smaller than those for services received by other mental health service users, $102 compared with $108.

TABLE 6

MENTAL HEALTH SERVICE USERS BY DIAGNOSIS

Entitlement	Schizophrenia	Affective Psychoses	Neuroses	Adjustment Reaction	Other	All Diagnoses
All Beneficiaries						
All Mental Health Service Users	9,259	6,228	6,850	2,963	5,457	30,757
	30.10	20.25	22.27	9.63	17.74	100.00
Received Services from a CSW	41	49	257	359	236	942
	4.35	5.20	27.28	38.11	25.05	100.00
Did Not Receive Services From a CSW						
All Mental Health Service Users Who Did Not Receive Services From a CSW	9,218	6,179	6,593	2,604	5,221	29,815
	30.92	20.72	22.11	8.73	17.51	100.00
Used Psychiatrist Services	8,881	5,817	5,280	2,276	4,765	27,019
	32.87	21.53	19.54	8.42	17.64	100.00
Did Not Use Psychiatrist Services	337	362	1,313	328	456	2,796
	12.05	12.95	46.96	11.73	16.31	100.00

The first line of the table is number of beneficiaries; the second line is percentage of beneficiaries.

Charges for All Medicare Part B Services

Charges for all Medicare Part B services received, including both mental health and nonmental health, were greater for persons who used mental health services than for persons who did not. Persons using CSW services had greater allowed charges for Part B services than either mental health service users who did not use services from a CSW or nonusers of mental health services. As shown in Table 7, those using at least one CSW service had an average of $2,358 in allowed charges per person year of eligibility, compared with $2,140 for other mental health service users and $1,058 for nonusers of mental health services. CSW users received an average of 68 services per person year; other mental health service users received 55; and nonusers of mental health services received 26.

The greater total Part B charges for mental health service users than for nonusers of mental health services, and for CSW users in particular, are attributable not only to the inclusion of charges for mental health services in the total, but also to much greater use of nonmental health services. Persons using mental health services, both those who used at least one CSW service and those who received mental health services only from providers other than a CSW, had use of and charges for nonmental health Part B services almost double those of nonusers of mental health services.

Whereas nonusers of mental health services received an average of 26 nonmental health services, with allowed charges of $1,058 per person year of eligibility, mental health service users received 51 services with allowed charges of $2,009. Among mental health service users, those with CSW use received more nonmental health services per person year of eligibility and had greater allowed charges than persons not receiving services from a CSW. CSW users received an average of 64 nonmental health services with an allowed amount of $2,235, compared with 51 services with allowed charges of $1,999 for mental health service users not using a CSW service.

This finding of greater use of nonmental health services by CSW users is driven by the utilization of disabled CSW users. Use of and charges for nonmental health services were similar for aged CSW users and aged mental health service users who did not use CSW services. However, disabled beneficiaries who received all of their mental health services from providers other than CSWs received 40 percent fewer nonmental health services, and allowed charges for these services were 33 percent less than those of the disabled who used CSW services.

This higher utilization may be caused by differences in the types of disabled beneficiaries in the two groups. Analysis of diagnosis and nonmental health service use for disabled CSW users suggests they were likely to be physically disabled, while those of disabled mental health service users who did not see a CSW suggests they were likely to be disabled because of mental impairment.

TABLE 7

AVERAGE USE OF AND CHARGES FOR TOTAL APPROVED PART B SERVICES PER PERSON YEAR OF ELIGIBILITY AND MENTAL HEALTH SERVICE UTILIZATION

Entitlement	CSW User	Mental Hlth. Svc. User Who Did Not Receive Services from a CSW	Nonuser of Mental Health Services	All Eligibles
All Beneficiaries				
No. of Users	1,424	14,342	18,851	34,617
No. of Svcs.	68	55	26	26
Charges				
Billed	$3,236	$3,032	$1,411	$1,454
Allowed	$2,358	$2,140	$1,058	$1,087
Reimbursed	$1,838	$1,661	$ 810	$ 832

ASSESSMENT OF IMPLEMENTATION AND OPERATION OF THE DEMONSTRATION

The demonstration provided an opportunity to examine the administrative feasibility of permanently recognizing CSWs as independent practitioners under Medicare and administrative issues that would have to be addressed before a program change is proposed. Issues covered in the implementation and operation assessment, described in the following sections, are provider selection, covered services, billing practices, reimbursement, claims processing and payment, and other administrative activities.

Provider Selection

Eligibility to participate in the demonstration was determined by State licensure, which is analogous to the criterion applied to physicians for participation in Medicare. Certification of CSWs and issuance of Medicare supplier identification numbers was implemented smoothly and efficiently. The selection procedure was simple and inexpensive for the carrier to administer because it was not necessary for the carrier or any other agency to establish new review processes and selection criteria.

Much consideration was given to whether salaried CSWs should be permitted to participate in the demonstration or whether direct reimbursement should be limited to those in private practice. Salaried CSWs were permitted to participate because interest in treating CSWs comparably to physicians and maximizing the number of CSWs eligible outweighed concerns that there would be greater potential for billing Medicare fraudulently.

Demonstration experience revealed no apparent administrative obstacles to including salaried CSWs in a permanent program. However, because data on CSW practices are not available and submitted claims did not provide the carrier with sufficient information to audit for certain types of fraud, the demonstration could not provide lessons on whether inclusion of salaried CSWs increased either the availability of services or the incidence of fraudulent billing.

Covered Services

CSWs were allowed to provide most mental health services covered under Medicare Part B. They were not permitted to provide services outside their legal range of practice, such as prescribing drugs, psychological testing, and electroshock therapy. The other important demonstration limitation was on the settings in which services could be provided.

In order to avoid potential double-billing, Medicare would not pay if services were provided in certain places of service and practice settings where a CSW's salary might be covered as a Part A expense. In addition, if services were provided as part of a CSW's employment by an organization that operates under a risk contract with Medicare, is paid on a capitation basis, or is paid on a cost basis that includes salaries of social workers as an allowable expense, Medicare would not pay. These settings included inpatient hospitals, long-term care facilities with Medicare-certified beds, home health agencies, dialysis units, hospices, and group practice prepayment plans with Medicare risk contracts.

The range of covered services appeared to be acceptable to most CSWs and there was no known evidence of fraudulent billing, although it should be noted that the carrier had no special procedures to audit for fraud and abuse. Some concern was raised by both Occidental and CSWs that excluding these places of service may have restricted access for beneficiaries with the greatest needs, and some believed that services in these excluded places could be included, especially if special audits were conducted.

Billing Practices

CSWs submitted claims using the same forms and procedures as other providers. The only special requirement was that salaried CSWs had to submit claims in their own names and could not bill under their employer's provider number. This requirement was imposed for the purposes of the demonstration to ensure that all CSW services could be identified for the assessment; it would not be necessary under a permanent program unless HCFA wanted to continue to be able

to distinguish the services of CSWs who were salaried or in multi-specialty group practices from those of other providers.

Problems with bills submitted by CSWs, according to Occidental, were typical of those of other new providers in the program. Initial confusion diminished over time as experience with billing Medicare increased. In fact, Occidental reported that CSW claims tended to be easier to process than claims from other providers, perhaps because CSWs were permitted to bill only a prescribed range of services, but also because information submitted was generally complete and accurate. The assignment rate on CSW claims was high (79 percent), although slightly lower than that on other mental health claims during the demonstration (84 percent).

Reimbursement

Prevailing charges for CSW services, with the exception of hospital-based services, were established using the procedures normally used when a new provider is added to Medicare. The prevailing charge for a particular procedure, however, could not exceed the prevailing charge for psychiatrists in Los Angeles County.

On the basis of experience in the demonstration, there would be no barriers to adopting normal Medicare procedures for establishing prevailing charges for CSW services in a permanent program. Prevailing charges were based on median prices reported by CSWs in a questionnaire. None of the median prices needed to be limited by the psychiatrists' prevailing charges.

Prevailing charges for hospital-based services were established using an alternate method because information needed to calculate them according to usual procedures was not available as a result of an oversight in designing the CSW certification application. However, it would be possible to follow standard procedures for hospital-based services if a permanent program were implemented.

Claims Processing and Payment

Because the actual claims volume was much smaller than had been projected, the level of effort required of the carrier to administer claims processing for the demonstration was lower than anticipated. Claims processing procedures were designed to be as consistent as possible with the carrier's existing procedures for processing outpatient mental health services, although some special procedures were used.

Only a small core of claims examiners were trained to handle CSW claims. Claims processing problems during the first 9 months of the demonstration were primarily the types that would be expected in the early stages of any new program. Most were administrative and were caused by CSW and beneficiary errors in completing claims forms and by problems with the carrier's staff following the special procedures established. The problems that did arise were handled without serious disruption of claims processing and payment.

Many problems were experienced in claims processing and payment during the demonstration. Most of these problems were caused by programming changes and errors in the data processing system that were not related specifically to CSW services. Others were caused by failures of special procedures for CSW claims, which were established because the program was temporary. The latter problems would not arise in a permanent program because CSW services presumably would be integrated in the normal claims processing system.

Some claims processing problems should be anticipated in the early stages of any new program, whether permanent or temporary. However, Occidental reported that CSW claims generally were less complicated to process than the average, perhaps partly because of the limited number of procedure codes they were permitted to bill.

Other Administrative Activities

Other administrative activities undertaken as a part of the demonstration were publicizing the program and monitoring the accuracy and validity of claims payment. Most publicity activities focused on informing CSWs about the demonstration. Less was done specifically to inform beneficiaries or other providers, who might have served as a source of referral to CSWs, about the demonstration, although flyers were mailed to beneficiaries with E.O.M.B. statements for 1 week at the beginning of the demonstration and efforts were made to publicize the demonstration through the local media.

Low utilization of the program suggests that publicity efforts may not have been successful, although little is known about awareness of the demonstration among providers and beneficiaries. If a permanent program were adopted and if increasing the actual, rather than potential, access to CSW services were an important goal, then a more concerted publicity effort might be in order.

Occidental's program integrity function conducts reviews of providers and beneficiaries suspected of fraud or abuse. The fact that Occidental had only one request for a hearing involving a CSW would indicate that there were no serious problems of widespread or blatant abuse of the program. However, Occidental could not monitor compliance with some of the restrictions placed on coverage of CSW services. If these restrictions were carried over into a permanent program, it might be appropriate to require that carriers establish special compliance audit procedures.

POLICY IMPLICATIONS

In the following sections, the policy implications of lessons learned from the demonstration are discussed in terms of access to mental health services for Medicare beneficiaries, utilization of mental health services, cost to Medicare of mental health and medical services, administrative feasibility, and the overall impact on the Medicare program.

Access

The study did not examine whether there was any problem with access to mental health services before the implementation of the demonstration and there was no independent evidence that access was a problem before or after the demonstration. However, recognition of CSWs as independent practitioners has the potential to increase access to mental health services for Medicare beneficiaries by substantially increasing the supply of available mental health service providers. One-third of the CSWs in the demonstration area were certified, and they increased by 80 percent the number of mental health specialists in the area participating in Medicare. However, the fact that increasing the supply of mental health service providers could also increase Medicare costs must also be recognized.

The effective increase in the availability of suppliers that CSWs represent is probably far less than is suggested by the number participating in Medicare because a much lower proportion of CSWs than of psychiatrists probably are available full-time for the delivery of therapy services. Furthermore, actual participation was low, with only 18 percent of the certified CSWs having one or more approved services. Consequently, an insignificant number of beneficiaries (less than 0.1 percent of the Medicare population) saw a CSW.

CSWs serve a different patient population than do other mental health service providers. They see primarily beneficiaries who are aged and have nonpsychotic mental health conditions, whereas far greater proportions of the beneficiaries served by other mental health service providers are disabled and have

psychotic conditions. Patients served by CSWs probably have fewer chronic mental health problems than those served by other providers, many of whom may be disabled because of chronic mental illness.

Utilization

If utilization during the demonstration is indicative of the level that could be expected under a permanent program, it appears that inclusion of CSWs in Medicare would have little impact on utilization of mental health services. This finding of low utilization is consistent with that under the Colorado Clinical Psychology/Expanded Mental Health Experiment, an earlier Medicare demonstration project that allowed direct reimbursement of nonphysician mental health providers. Few CSW services were provided, and they represented only 3 percent of all approved mental health services.

CSWs provide different types of services than do other mental health service providers. They rely more on psychosocial interventions than do psychiatrists and other providers, who use medications extensively. CSWs provide mainly 50 minutes of individual therapy and are far more likely than other providers of mental health services to deliver group and family therapy services.

A much higher proportion of CSW services are delivered in a patient's home than are mental health services from providers who were not CSWs. This fact suggests either that CSWs are providing access to services for homebound patients or that services are provided in the home to evaluate the patient's social environment in order to facilitate treatment.

Cost

During temporary extension of coverage of CSW services in the demonstration, the level of CSW utilization was low. Only if the low level of utilization of CSW services were maintained after a permanent expansion of coverage would direct reimbursement of CSWs be likely to have minimal additional effect upon Medicare costs. If, however, beneficiaries changed their behavior and

increased their level of CSW utilization, then Medicare could incur significant costs for direct reimbursement of CSWs.

The results of the demonstration also show that Medicare would not achieve savings -- and could impose added costs -- through direct substitution of CSW services for those of psychiatrists, even though CSW-allowed charges are less, both for the same procedures and for the overall mix of services each delivers. There would be no savings because some evidence for the demonstration suggests that, for some types of patients, CSW services may not be direct substitutes for mental health services from psychiatrists and other providers.

CSW users received more mental health services and, with the exception of patients diagnosed with adjustment reaction, had higher allowed charges than mental health service users having the same diagnosis who did not use CSW services when overall mental health treatment patterns, including all mental health services from all types of providers, are compared. Thus, use of CSW services was not offset by an equivalent reduction in use of mental health services from psychiatrists and other providers, and CSW services may be partly add-on services.

There is no evidence that the increased cost to Medicare, which CSW services would represent if they were add-ons, is offset by a reduction in use of nonmental health services. The utilization of and allowed charges for nonmental health services for aged CSW users were roughly equivalent to those of aged mental health service users who did not see a CSW.

Disabled CSW users had substantially more nonmental health service than disabled mental health service users who did not see a CSW. Analysis of diagnosis and nonmental health service use for disabled CSW users suggests they were likely to be physically disabled, while those of disabled mental health service users who did not see a CSW suggests they were likely to be disabled because of mental impairment.

Beneficiaries with physical disabilities could be expected to have substantially higher use of and charges for nonmental health services than

beneficiaries with mental disabilities. Because CSW users and other mental health services users, particularly those who are disabled, appear to be very different populations, it cannot be concluded that use of CSW services increases use of nonmental health services. However, there is also no evidence that CSW service use reduces use of nonmental health services.

Administrative Feasibility

Overall, experience under the demonstration indicates that inclusion of CSWs in Medicare is administratively feasible. After initial questions about program design were resolved and the inevitable problems in the early phases of implementation were surmounted, administering the program was straightforward for the carrier and required minimal additional effort. Most ongoing problems were caused either by administrative decisions made because of the temporary nature of the program or as a result of other decisions made by the carrier that were not specifically related to direct reimbursement of CSWs.

Claims processing, particularly data processing, was probably the greatest source of problems. The problems were not inherent in CSW services per se and were more the result of the program's newness. Historically, any Medicare program change that affects data processing systems has created problems for carriers, and the problems created by inclusion of CSWs would probably be no greater than those caused by other changes.

Although the demonstration suggests that direct reimbursement of CSWs is administratively feasible, some general policy questions would need to be resolved if a permanent program were proposed. These are:

- What eligibility criteria should be applied in States where CSWs are not licensed?

- Should participation be open to salaried CSWs in order to maximize the potential supply of providers? If so, what administrative oversight is warranted to reduce the potential for abusive duplicate billings?

- Should CSWs be restricted as to allowable places of service and practice settings to avoid potential double-billing of Medicare, or should special audits be developed for CSW services to ensure that this does not happen?

- Should prevailing charges for CSW services be explicitly limited to less than those of psychiatrists to ensure that CSW services would not cost more than the same services from a psychiatrist, when Medicare ordinarily does not apply such limitations on reimbursement to particular specialty groups?

Conclusion

This demonstration project has shed some light on the likely impact of including CSWs in Medicare, but limitations in the study's design mean that these findings should be treated with caution. The feasibility of administering a program for direct reimbursement of CSWs has been shown, but the extent to which other findings, such as the level of utilization of mental health services, may be generalized is not yet known. Clearly, the effect of direct reimbursement upon the volume of services provided by CSWs could have major implications for Medicare costs.

In this demonstration, the level of utilization of CSW service providers was low, but whether or not this would be the case on a national scale is not known. If low utilization levels continued, then the additional costs for Medicare would not be great; however, if this were not the case, then Medicare could incur significant additional costs. Utilization levels might be higher than in the demonstration if all beneficiaries were eligible on a permanent basis; moreover, the increase in the mental health cap under P.L. 100-203, passed after completion of this study, could raise utilization levels.

An additional reason for making no changes in direct reimbursement policy is that there is no clear-cut evidence that Medicare would experience cost savings by extending reimbursement to CSWs. Because of important differences in the types of mental health services received by users who saw a CSW and those who did not, comparisons of overall treatment costs are misleading. Instead, comparisons should

be limited to users with the same diagnosis. In this instance, the evidence suggests that users seeing a CSW may have somewhat more costly overall mental health treatment patterns than those who did not.

Since the demonstration provided no evidence that coverage of CSW services would reduce the overall cost of the Medicare program, the Department does not recommend changing the current statute concerning coverage of CSWs. The low level of CSW utilization in the demonstration is additional justification for not changing the current policy.